

**CHILD DEVELOPMENT SERVICES
CIVILIAN MEDICAL CONSENT AUTHORIZATION**

(TO BE USED BY CIVILIAN FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. This form is a legal document and must be filled out completely and correctly to be valid. **NO CORRECTIONS ARE ACCEPTABLE!**

To: Health Services Clinic,

I, _____, am the parent or lawful guardian of the child named below, and entitled to medical care at your facility.

Full Name: _____ Age: _____

Address: _____ Phone: (____) _____

Ins. Co. Name: _____

Ins. Co. Address: _____, (If available)
(Street)

_____, _____, _____
(City) (State) (Zip)

Ins. ID Card #: _____

Ins. Effective Date: _____

(Insured's name) (SSN) (Agency/Work location)

I _____ appoint the Director in Charge of the Child Development Center to be my lawful Attorney-in-fact (agent) for the purpose specified herein.

I also appoint:

(Name) (Phone number)

(Signature) (Date)

(Address) (Relationship)

to act as my Attorney-in-Fact and to perform, or consent to performance of, any and all acts that I might perform or give my consent to be performed, if I were present, for the following purpose.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the _____ Medical Facility/Practitioner, or any Hospital, Clinic, Etc., plus any duly licensed medical practitioner for the health and well being of my child(ren) aforementioned. I understand that the staff of the _____ Medical Facility/Practice may include, in addition to Physicians and Dentists, Nurses and Physicians Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child(ren).

I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on _____, _____ and terminate on _____, _____.

Witnessed:

Date: _____

The person signing this form is known to me to be the parent/legal guardian of the above named child(ren).

(Signature of witness)

(Printed name)